PRINTED: 05/19/2011 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-0391
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	DING	01	COMPI	LETED
		155666	A. BUILDING B. WING			04/25/2011	
		l	B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	R			/ESLEY ROAD		
///EGI E/	/ HEALTHCARE				RN, IN46706		
WESLE	THEALTHCARE		_	AUBUR			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0000							
K0000	and State Licer conducted by to Department of accordance with Survey Date: Of Facility Number Provider Number: Surveyor: Amy Code Specialist At this Life Saff Wesley Health of in compliance for Participation Medicare/Medicare/Medicare/Medicare/Medicare from Fire and to the National Fith Association (Nith Code (LSC), Chromogeneous Conducted Subpart Association (Nith Code (LSC), Chromogeneous Chro	th 42 CFR 483.70(a). 24/25/11 er: 000307 per: 155666 100285660 y Kelley, Life Safety t fety Code survey, care was found not with Requirements on in icaid, 42 CFR 0(a), Life Safety the 2000 edition of re Protection FPA) 101, Life Safety eapter 19, Existing eccupancies and 410	KO	0000	The creation and submission this plan of correction does constitue an admission by the provider of any conclusions forth in the statement of deficiencies, or of any violar regulation. This provider respectfully requests that the 2567 plan of correction be considered as the letter of credible allegation and requidesk review in lieu of a possurvey review on or after M 2011.	not his set tion of ne	
	-	be of Type V (111)					
	construction and was fully						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

FNJN21

Facility ID:

000307

TITLE

PRINTED: 05/19/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Ì		STRUCTION 01	X3) DATE SURVEY COMPLETED		
		155666	A. BUILDIN B. WING	lG		04/25/20		
NAME OF B	ROVIDER OR SUPPLIER			ΓREET AD	DRESS, CITY, STATE, ZIP CODE			
			1751 WESLEY ROAD					
	HEALTHCARE		A	UBURN	I, IN46706			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION		
TAG	`	LSC IDENTIFYING INFORMATION)		TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		E	DATE	
	sprinklered. The facility has a fire							
	alarm system w	•						
		e corridors, areas						
	open to the cor	ridors and resident						
	rooms. The fac	cility has a capacity						
	of 69 and had a	a census of 43 at						
	the time of this	survey.						
Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 04/29/11.								
	The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:							
K0025 SS=E	least a one half ho accordance with 8 terminate at an atr protected by fire-ra glass panels and s two separate compleach floor. Dampe penetrations of sm heating, ventilating systems. 19.3.7	e constructed to provide at our fire resistance rating in .3. Smoke barriers may rium wall. Windows are ated glazing or by wired steel frames. A minimum of partments are provided on ers are not required in duct noke barriers in fully ducted g, and air conditioning 7.3, 19.3.7.5, 19.1.6.3,	K002		KO25 NEDA 101 LIEE SAFET	~	05/02/2011	
	Based on obser interview, the f ensure 2 of 20 caused by the p and/or conduit	acility failed to penetrations	K002	5	K025 NFPA 101 LIFE SAFET CODE STANDARD1. The Maintenance man inspected sealed all nonconforming gap the East Hall Fire Barrier Wal The Maintenance man or his designee will inspect the fire	and os on II.2.	05/03/2011	

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Event ID: FNJN21 Facility ID:

000307

If continuation sheet

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 01	COMPI		
		155666	A. BUI B. WIN	LDING		04/25/2	2011
			D. WIN		DDRESS, CITY, STATE, ZIP CODE	1	
NAME OF I	PROVIDER OR SUPPLIEF	8			ESLEY ROAD		
WESLEY	' HEALTHCARE			AUBUR	N, IN46706		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG		ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	H CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY)	
	barrier wall we	re protected to			barrier wall on a monthly ba		
	maintain the si	moke resistance of			The results of the inspection be brought to QA for trackin		
	each smoke ba	rrier. LSC Section			quarterly for one year then	9	
	19.3.7.3 requii	res smoke barriers			annually thereafter.		
	to be construct	ted in accordance					
	with LSC Section	on 8–3. LSC Section					
	8.3.6.1 require	s the passage of					
	building servic	e materials such as					
	pipe, cable or v	wire to be protected					
so the space between the							
penetrating item and the smoke							
barrier shall be filled with a							
	material capab	le of maintaining					
	the smoke resi	stance of the smoke					
	barrier or be p	rotected by an					
	approved device	ce designed for the					
	' ' '	se. This deficient					
		affect two of four					
	smoke compar	tments.					
	 Findings includ	le:					
	Based on obse	rvation with					
		ctor on 04/25/11 at					
		re was a one fourth					
	· · ·	gap around each of					
	the two clear p	- •					
	· ·	the attic east hall					
	smoke barrier	wall. This was					
	acknowledged	by the Executive					
	Director at the						
	observation.						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155666			(X2) MULTIPLE A. BUILDING B. WING	01	l` ´	E SURVEY PLETED /2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1751 WESLEY ROAD AUBURN, IN46706				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION: CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
K0029 SS=D	3.1–19(b) One hour fire rated fire-rated doors) of extinguishing syste and/or 19.3.5.4 pro When the approve extinguishing syste are separated from resisting partitions self-closing and no protective plates the from the bottom of 19.3.2.1 Based on observinterview, the final frame. This defination are sider could affect and the event of an Findings included Based on an ob-Administrator and Director on 04/p.m., the clean corridor door director door of extinguishing systems.	d construction (with ¾ hour ran approved automatic fire em in accordance with 8.4.1 of beets hazardous areas. It dautomatic fire em option is used, the areas in other spaces by smoke and doors. Doors are on-rated or field-applied that do not exceed 48 inches if the door are permitted. Evation and accility failed to ridor door to 1 of 1 its, such as laundry into the door ficient practice was not care area but y number of staff in emergency. e: Eservation with the and Executive (25/11 at 1:15 laundry room id self close, but it not the door frame. med by the and Executive	K0029	K0029The facility er outside door repair of Door Company) to cadjust the clean laur door. This service we completed on May 0	company (A1 check and ndry room vas	05/03/2011	

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AND PLAN OF CORRECTION IDENTIFIC		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155666		LDING	NSTRUCTION 01	(X3) DATE: COMPI 04/25/2	ETED
NAME OF PROVIDER OR WESLEY HEALTHC		2	STREET ADDRESS, CITY, STATE, ZIP CODE 1751 WESLEY ROAD AUBURN, IN46706				
PREFIX (EACH	DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
3.1–19(b) SS=C Fire drills varying coshift. The is aware throutine. For conducting competen exercise to conducted announce audible also Based or interview conduct unexpect quarters affects a Findings Based or Report Administ Director p.m., all place be 11:20 a. quarters	are held nditions staff is nat drills espons drills is persor eadersh between ment ma arms. I recor v, the f quarte ted tin . This Il occu include forms trator on 04 first s tween m. for . This	at unexpected times under s, at least quarterly on each familiar with procedures and s are part of established ibility for planning and s assigned only to as who are qualified to ip. Where drills are en 9 PM and 6 AM a coded ay be used instead of 19.7.1.2 and review and facility failed to erly fire drills at thes for 4 of 4 deficient practice apants.	K	0050	K 00501. The Administrator of designee will conduct first shifted drills at various times durithe entire 8 hour shift.2. The results will be brought to QA tracking and trending quarter one year then annually there	nift ring e for rly for	05/03/2011

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155666		(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE COMPI 04/25/2	LETED	
	PROVIDER OR SUPPLIER		1751 W	ADDRESS, CITY, STATE, ZIP CODE /ESLEY ROAD RN, IN46706	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE .	(X5) COMPLETION DATE
K0062 SS=E	3.1–19(b) 3.1–51(c) Required automate continuously main condition and are periodically. 19.25, 9.7.5 Based on observing the feasure the spray sprinkler heads room was unoby. 7.5 requires sprinkler system tested and main accordance with Standard for the Testing and Mater–Based Fifestems. NFPA 2–2.1.2 states obstructions to shall be correctly practice could in the main dimensional findings included the spray of the sp	ic sprinkler systems are tained in reliable operating inspected and tested .7.6, 4.6.12, NFPA 13, NFPA evation and facility failed to ay pattern for 3 of 8 in the main dining ostructed. LSC all automatic ms be inspected, ntained in h NFPA 25, he inspection, aintenance of re Protection a 25, Section unacceptable o spray patterns ted. This deficient affect all residents ling room.	K0062	K 0062 The facilility has h identified light fixtures more sufficiently away from the sprinkler heads so the sprinkler will not be obstructionary way.	ved ay	05/03/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF A. BUILDING 01 COMPLET					
		155666	A. BUII B. WIN			04/25/2	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1751 WESLEY ROAD AUBURN, IN46706				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX (EACH		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	(EACH CORRECTIVE ACTION SHOULD BE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DEFICIENCY)	
K0144 SS=F	ceiling light fix inches from each This was acknown Administrator and observation. 3.1–19(b) Generators are insexercised under lownonth in accordance 3.4.4.1. 1. Based on obsinterview, the fivenesure 1 of 1 enders are mote manual requires emerging providing power lighting system tested and main accordance with Standard for Enders Standard for Enders Standard for Enders Level I have a remote of a type similar station located	spected weekly and load for 30 minutes per loce with NFPA 99. Diservation and lacility failed to loce mergency loce equipped with a location at location and loc	K	0144	K01441. EMERGENCY SHUTOFF FOEMERGENCY GENERATOR The facility had an emergency shutoff switch mounted in the corridor outside of the transfesswitch room.2. LETTER OF RELIABILTY FOR FUEL SOURCE. The facility has contacted and received an acceptable letter of reliability fuel source from our natural (provider (Northern Indiana Finand Light). See Attached PD File.	R. cy e er for gas uel	05/18/2011
	of a type simila station located housing the pri 37, Standard fo	r to a break-glass outside the room					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155666		A. BUI	LDING	onstruction 01	(X3) DATE : COMPL 04/25/2	ETED	
		100000	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	04/20/2	
NAME OF I	PROVIDER OR SUPPLIER	R			ESLEY ROAD		
WESLEY HEALTHCARE					RN, IN46706		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION DATE
1110		as Turbines, 1998	<u> </u>	1110			DATE
	Edition, at 8-2						
) horsepower or					
	_	vision for shutting					
	· ·	ne at the engine and					
	from a remote	_					
		ice could affect all					
	occupants.	ice could affect an					
	occupants.						
	Findings include:						
	Based on observation with the						
	Administrator and Executive						
		/25/11 during a					
		ility from 12:45					
		.m., the facility did					
	'	note manual stop for					
		generator. Based					
	on an interviev	_					
	Administrator						
	Director at 12:						
		a 350 cubic inch,					
	V-8 engine.	- ,					
	3-1.19(b)						
	2 Pacadon in	iterview and record					
		ility failed to ensure					
	· ·	l source for 1 of 1					
	' '	nerators was from a					
		. NFPA 110 1999					
		ard for Emergency					
	and Standby Po	ower Systems,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155666		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/25/2011		
	PROVIDER OR SUPPLIER		B. WIIV	1751 W	DDRESS, CITY, STATE, ZIP CODE ESLEY ROAD N, IN46706	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	states the follo sources shall be for the emerge (EPS): a) Liquid petrol atmospheric probe Liquifed petrol or vapor withder (C) Natural or system (EPS) is a liquid petrol of the following single probability of its off-site fuel sure due to earthque or demonstrate unreliability), of alternate energe to allow full out to allow full out to emergency power (EPSS) to be despecified shall the provision for transfer from the source to the assource. CMS (Centers for Medicare/Medicare/Medicare/Medicare) a letter the natural gas	e permitted for use ncy power supply leum products at ressure roleum gas (liquid rawal) withetic gas. Level 1 locations where the interruption of pplies is high (e.g., ake, flood damage ed utility in-site storage of an any source sufficient tput of the ver supply system livered for the class be required, with or automatic the primary energy lternate energy					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 01	ì í	ESURVEY	
THIE TEAM	or condition	155666		LDING		04/25/	
		10000	B. WIN		.DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	ESLEY ROAD		
WESLEY	HEALTHCARE				N, IN46706		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE
IAG			+	IAG	DEI REIERCT)		DATE
	1. A statement						
	reliability of the	e natural gas					
	delivery.						
	2. A brief desc	·					
		atement regarding					
	the reliability.	that there is a low					
	-	nterruption of the					
	natural gas.	rintian that					
	4. A brief description that						
	supports the statement regarding						
	the low probability of interruption, 5. The signature of a technical						
	person from th						
	provider.	e natural yas					
	•	oractice could affect					
	all occupants.	ractice could affect					
	an occupants.						
	Findings includ	e:					
	Based on interv						
	Administrator a	and Executive					
		/25/11 at 12:45					
	p.m., the fuel s						
		erator was natural					
	_	lly, based on record					
		lity did have a letter					
		ral gas provider					
	, ,	June 30, 2008 but					
		ot include all the					
	items above re	quired for a letter					
	confirming the						
	natural gas fue	I source for an					

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		155666	A. BUILDING B. WING		04/25/2011
NAME OF F	PROVIDER OR SUPPLIER		l l	FADDRESS, CITY, STATE, ZIP CODE WESLEY ROAD	•
WESLEY	'HEALTHCARE			JRN, IN46706	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I	BE COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE DATE
		erator. The letter			
		ing statements of tural gas and low			
		nterruption of the			
	natural gas ser				
	acknowledged Administrator a				
		the time of record			
	review.	,			
	3.1-19(b)				